Waiver 5 Home and Community Based Services
Freedom of Choice and Consent Form eff. 7/1/08

Applicant Name _____ SSN _____

I have been fully informed of services available through the Medicaid Home and Community-Based Services Waiver Program. These services are potentially available to all DDP-funded service recipients funded with state general funds. The choice of service provider and choice of services are available to all persons in DDP funded services subject to the cost plan limits.

I have been advised that if my needs cannot be adequately and safely met in the community, I will not be offered DDP-funded services. I have also been advised that if while in DDP-funded services my condition deteriorates to the point that I cannot be maintained safely in the community, I could be subject to placement in a more restrictive setting (e.g. a nursing home or an ICF- MR).

I have been informed that I have the right to request a Montana Department of Justice criminal back ground check at no personal cost to me for any person providing me with homemaker services. I understand that employees of agencies under contract with the State providing my DDP-funded services are required to have background checks.

*I have also been fully informed of services available in an ICF- MR facility, including the judicial process involved in the placement of persons in an ICF- MR facility.
*I have been advised of the State of Montana fair hearing process if I am denied the service(s) of choice or the provider(s) of choice.
*I have been informed of the conditions under which I may choose to self-direct my 0208 Waiver services.
*I have been fully informed that I will be given the opportunity to choose the provider of service(s) when more than one provider is available to render the service(s).

After reviewing my options and choices, I freely choose to (*check all that apply*):
_____ Receive services in the community via the HCBS DD Medicaid Waiver.
_____ Receive services from my existing provider(s).
_____ Receive services from a different provider (specify).
_____ Self direct my 0208 Waiver services via an agency with choice service model, if I qualify for this service option.
_____ Not receive DD Services at this time. I no longer need DD services.

Comments _____

_____

_____
Client/Guardian or Personal Representative Date

_____
Targeted CM or C&F Provider Representative Date

_____
Department Representative Date